MDS-ALS: The Mini-Series
Session #2

Case Mix Team

June 2022

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MDS-ALS
Mini-series #2

MDS-ALS Training: Agenda

- Basic Assessment Tracking Form
- Section S: Setting the ARD
- Section S: Completing the assessment
- Section A
- Section B, C, and D
- Section F, H, and I
- Section K, L, and N
- Section O and Q
- Section R, T, and U
- Discharge Tracking form
- Submission of Assessments

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MDS-ALS Training

MDS-ALS Assessment Tool

Section by Section

Means payment item

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MDS-ALS Training

MDS-ALS Payment Items for Adult Family Care Homes

MDS-ALS Payment Item	Description
B3	Cognitive Skills for Daily Decision-Making
E1a-E1r	Indicators of Depression, Anxiety, and/or Sad Mood
G1aa-G1ga	ADL Self-Performance (excluding stairs)
G2	Bathing Self-Performance
G5Aa-G5Ai	IADL Self-Performance
H4	Use of Incontinent Supplies
O5F	Self-Administered Medications: Over-the Counter Meds
O6	Medication Preparation and Administration
P10	Physician Orders

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Section S: Assessment Information and Signatures

SECTION S. ASSESSMENT INFORMATION

1.	PARTICIPATION IN ASSESSMENT	a. Resident: ☐ 0. No ☐ 1. Yes b. Family: ☐ 0. No ☐ 1. Yes ☐ 2. No Family c. Other Non-Staff: ☐ 0. No ☐ 1. Yes ☐ 2. None
2.	SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:	
	a. Signature of Assessment Coordinator (sign on line above)	
	b. Date Assessment Coordinator signed as complete ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)	
	c. Other Signatures / Title / Sections / Date	
	d. / Date	
	e. / Date	
3.	CASE MIX GROUP	☐☐☐☐☐

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1.	RESIDENT NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER	☐ 1. Male ☐ 2. Female
3.	BIRTHDATE	☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)
4.	RACE/ ETHNICITY (Check only one)	☐ 1. American Indian/Alaskan Native ☐ 2. Asian/Pacific Islander ☐ 3. Black, not of Hispanic origin ☐ 4. Hispanic ☐ 5. White, not of Hispanic origin ☐ 6. Other
5.	SOCIAL SECURITY and MEDICARE NUMBERS (C in 1st box if no med. no.)	a. Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐ b. Medicare number (or comparable railroad insurance number) ☐☐☐☐☐☐☐☐☐ – ☐☐
6.	FACILITY NAME AND PROVIDER NO.	a. Facility Name b. Provider No. ☐☐☐☐☐☐☐☐☐
7.	MAINECARE NO.	[Record a "+" if pending, "N" if not a MaineCare recipient] ☐☐☐☐☐☐☐☐☐

Section AA: Identification Information.

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Face Sheet: Background Information
Completed at the time of the resident's initial admission to the facility.

Section AB: Demographic Information
Section AC: Customary Routine
Section AD: Face Sheet Signatures and dates

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Section A: Identification and Background information

1.	RESIDENT NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	SOCIAL SECURITY and MEDICARE NUMBERS (C in 1st box if no med. no.)	a. Social Security Number b. Medicare number (or comparable railroad insurance number)
3.	FACILITY NAME AND PROVIDER NO.	a. Facility Name b. Provider No.
4.	MAINECARE NO.	[Record a "+" if pending, "N" if not a MaineCare recipient]
5.	ASSESSMENT DATE	Last day of observation period Month Day Year
6.	REASON FOR ASSESSMENT	(Check primary reason for assessment) 1. Admission assessment 2. Annual assessment 3. Significant change in status assessment 4. Semi-Annual 5. Other (specify)

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Section B: Cognitive Patterns

1.	MEMORY	(*Recall of what was learned or known*) a. Short-term memory OK—seems/appears to recall after 5 minutes ☐ 0. Memory OK ☐ 1. Memory problem b. Long-term memory OK—seems/appears to recall long past ☐ 0. Memory OK ☐ 1. Memory problem
2.	MEMORY/ RECALL ABILITY	(*Check all that resident was normally able to recall during* ***last 7 days***) ☐ a. Current season ☐ d. That he/she is in a facility/home ☐ b. Location of own room ☐ e. NONE OF ABOVE are recalled ☐ c. Staff names/faces
3.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING (Check only one)	(*Made decisions regarding tasks of daily life*) ☐ 0. *INDEPENDENT*—decisions consistent/reasonable ☐ 1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only ☐ 2. *MODERATELY IMPAIRED*—decisions poor; cues/ supervision required ☐ 3. *SEVERELY IMPAIRED*—never/rarely made decisions
4.	COGNITIVE STATUS (Check only one.)	Resident's cognitive status or abilities now compared to resident's status 180 days ago (or since admission if less than 180 days). ☐ 0. No change ☐ 1. Improved ☐ 2. Declined

Modified Cognitive Skills		If value B3>0 then Score=1, otherwise score =0
B3	Cognitive skills for daily decision-making	

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SECTION C. COMMUNICATION/HEARING PATTERNS

1.	HEARING (Check only one.)	(*With hearing appliance, if used*) ☐ 0. *HEARS ADEQUATELY*—normal talk, TV, phone ☐ 1. *MINIMAL DIFFICULTY* when not in quiet setting ☐ 2. *HEARS IN SPECIAL SITUATIONS ONLY*—speaker has to adjust tonal quality and speak distinctly ☐ 3. *HIGHLY IMPAIRED* –absence of useful hearing
2.	COMMUNICA-TION DEVICES/ TECHNIQUES	(*Check all that apply during last 7 days.*) ☐ a. Hearing aid, present and used ☐ b. Hearing aid, present and not used regularly ☐ c. Other receptive communication techniques used (e.g., lip reading) ☐ d. *NONE OF ABOVE*
3.	MAKING SELF UNDERSTOOD (Check only one.)	(*Expressing information content—however able*) ☐ 0. *UNDERSTOOD* ☐ 1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts ☐ 2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests ☐ 3. *RARELY/NEVER UNDERSTOOD*
4.	ABILITY TO UNDERSTAND OTHERS (Check only one.)	(*Understanding information content—however able*) ☐ 0. *UNDERSTANDS* ☐ 1. *USUALLY UNDERSTANDS*—may miss some part / intent of message ☐ 2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication ☐ 3. *RARELY/NEVER UNDERSTANDS*

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SECTION D. VISION PATTERNS

1.	VISION (Check only one.)	*(Ability to see in adequate light and with glasses if used)* ☐ 0. *ADEQUATE*—sees fine detail, including regular print in newspapers/books ☐ 1. *IMPAIRED*—sees large print, but not regular print in newspapers/books ☐ 2. *MODERATELY IMPAIRED*—limited vision; not able to see newspaper headlines, but can identify objects ☐ 3. *HIGHLY IMPAIRED*—object identification in question, but eyes appear to follow objects ☐ 4. *SEVERELY IMPAIRED*—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects
2.	VISUAL APPLIANCES	a. Glasses, contact lenses ☐ 0. No ☐ 1. Yes b. Artificial eye ☐ 0. No ☐ 1. Yes

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SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVEMENT (Check all that apply.)	☐ a. At ease interacting with others ☐ b. At ease doing planned or structured activities ☐ c. At ease doing self-initiated activities ☐ d. Establishes own goals ☐ e. Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services) ☐ f. Accepts invitations into most group activities ☐ g. *NONE OF ABOVE*
2.	UNSETTLED RELATION-SHIPS (Check all that apply.)	☐ a. Covert/open conflict with or repeated criticism of staff ☐ b. Unhappy with roommate ☐ c. Unhappy with residents other than roommate ☐ d. Openly expresses conflict/anger with family/friends ☐ e. Absence of personal contact with family/friends ☐ f. Recent loss of close family member/friend ☐ g. Does not adjust easily to change in routines ☐ h. *NONE OF ABOVE*
3.	LIFE-EVENTS HISTORY (Check all that apply.)	Events in past 2 years ☐ a. Serious accident or physical illness ☐ b. Health concerns for other person ☐ c. Death of family member or close friend ☐ d. Trouble with the law ☐ e. Robbed/physically attacked ☐ f. Conflict laden or severed relationship ☐ g. Loss of income leading to change in lifestyle ☐ h. Sexual assault/abuse ☐ i. Child custody issues ☐ j. Change in marital/partner status ☐ k. Review hearings (e.g., forensic, certification, capacity hearing) ☐ l. *NONE OF ABOVE*

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Note: this section has a **14-day** look back period.

1. CONTINENCE SELF-CONTROL CATEGORIES
(Code for resident's PERFORMANCE OVER ALL SHIFTS)

0. *CONTINENT*—Complete control (includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool)
1. *USUALLY CONTINENT*—BLADDER, Incontinent episodes once a week or less; BOWEL, less than weekly
2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week
3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g. on day shift); BOWEL, 2-3 times a week
4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed			
b.	BLADDER CONTINENCE	Control of urinary bladder function with appliances (e.g. foley) or continence programs, if employed			
2.	BOWEL ELIMINATION PATTERN	Bowel elimination pattern regular—at least one movement every three days	a.	Diarrhea	c.
		Constipation	b.	Fecal Impaction	d.
				Resident is independent	e.
				NONE OF ABOVE	f.
3.	APPLIANCES and PROGRAMS	Any scheduled toileting plan	a.	Did not use toilet room/ commode/urinal	f.
		Bladder retraining program	b.		
		External (condom) catheter	c.	Pads/briefs used	g.
		Indwelling catheter	d.	Enemas/irrigation	h.
		Intermittent catheter	e.	Ostomy present	i.
				NONE OF ABOVE	j.

4. USE OF INCONTINENCE SUPPLIES *(Check only one.)*

Resident's management of incontinence supplies (pads, briefs, ostomy, catheter) in **last 14 days**.

- ☐ 0. Always continent
- ☐ 1. Resident incontinent and able to manage incontinence supplies independently.
- ☐ 2. Resident incontinent and receives assistance with managing incontinence supplies.
- ☐ 3. Resident incontinent and does not use incontinence supplies.

Management of Incontinence Supplies		If H4=0, Score=0; If H4=1, Score=1; If H4=2, Score=2; If H4=3, Score=0
H4	Ability to manage incontinent supplies	

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POP QUIZ !

0 - Continent – Complete control

1 - Usually Continent – Bladder, incontinent episodes occur once a week or less. Bowel incontinent episodes occur less than once a week.

2 - Occasionally Incontinent – Bladder incontinent episode occur two or more times a week but not daily. Bowel incontinent episodes occur once a week.

3 - Frequently Incontinent – Bladder, tended to be incontinent daily, but some control present (e.g., on day shift) Bowel, 2-3 times a week.

4 - Incontinent – Bladder incontinent episodes occur multiple times daily. Bowel incontinence is all (or almost all) of the time.

A. Mr. Q was taken to the toilet after every meal, before bed, and once during the night. He was never found wet.

B. Mr. R had an indwelling catheter in place during the entire 14-day assessment period. He was never found wet.

C. Although she is generally continent of urine, every once in a while (about once in two weeks) Mrs. T doesn't always make it to the bathroom in time after receiving her daily diuretic pill

D. Late in the day when she is tired, Mrs. A sometimes (but not all days) has more episodes of urinary incontinence.

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Section I: Diagnosis

All diseases and conditions must have physician documented diagnosis in the clinical record.

Do not include conditions that have been resolved or no longer affect the resident's functioning or service plan.

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Section K: Oral and Nutritional Status

SECTION K. ORAL/NUTRITIONAL STATUS

1.	ORAL PROBLEMS *(Check all that apply.)*	☐ a. Mouth is "dry" when eating a meal ☐ b. Chewing Problem ☐ c. Swallowing Problem ☐ d. Mouth Pain ☐ e. *NONE OF ABOVE*
2.	HEIGHT AND WEIGHT	*Record **(a.) height in inches** and **(b.) weight in pounds**. Base weight on most recent measure in **last 30 days**; measure weight consistently in accord with standard facility practice–e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes.* a. HT (in.) ☐☐ b. WT (lb.) ☐☐☐
3.	WEIGHT CHANGE	**a. Unintended weight loss–5% or more in last 30 days; or 10% or more in last 180 days** ☐ 0. No ☐ 1. Yes **b. Unintended weight gain–5% or more in last 30 days; or 10% or more in last 180 days** ☐ 0. No ☐ 1. Yes
4.	NUTRITIONAL PROBLEMS OR APPROACHES *(Check all that apply.)*	☐ a. Complains about the taste of many foods ☐ b. Regular or repetitive complaints of hunger ☐ c. Leaves 25% of food uneaten at most meals ☐ d. Therapeutic diet ☐ e. Mechanically altered (or pureed) diet ☐ f. Noncompliance with diet ☐ g. Eating disorders ☐ h. Food allergies *(specify)* _____ ☐ i. Restrictions *(specify)* _____ ☐ j. *NONE OF ABOVE*

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Section L: Oral / Dental Status

SECTION L. ORAL/DENTAL STATUS

1.	ORAL STATUS AND DISEASE PREVENTION *(Check all that apply.)*	☐ a. Has dentures or removable bridge ☐ b. Some/all natural teeth lost–does not have or does not use dentures (or partial plates) ☐ c. Broken, loose or carious teeth ☐ d. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes ☐ e. Daily cleaning of teeth/dentures or daily mouth care–by resident or staff ☐ f. Resident has difficulty brushing teeth or dentures ☐ g. *NONE OF ABOVE*

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Section N: Activity Pursuit Patterns

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	***(Check appropriate time periods over last 7 days)*** Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: ☐ a. Morning ☐ d. Night (Bedtime to A.M.) ☐ b. Afternoon ☐ e. *NONE OF ABOVE* ☐ c. Evening
2.	AVERAGE TIME INVOLVED IN ACTIVITIES *(Check only one.)*	***(When awake and not receiving treatments or ADL care)*** ☐ 1. Most–more than 2/3 of time ☐ 2. Some–from 1/3 to 2/3 of time ☐ 3. Little–less than 1/3 of time ☐ 4. None
3.	PREFERRED ACTIVITY SETTINGS	***(Check all settings in which activities are preferred)*** ☐ a. Own room ☐ d. Away from facility ☐ b. Day/activity room ☐ e. *NONE OF ABOVE* ☐ c. Outside facility (e.g., in yard)
4.	GENERAL ACTIVITY PREFERENCES	***(Check all PREFERENCES whether or not activity is currently available to resident)*** ☐ a. Cards/other games ☐ k. Gardening or plants ☐ b. Crafts/arts ☐ l. Talking or conversing ☐ c. Exercise/sports ☐ m. Helping others

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Section O: Medications

SECTION O. MEDICATIONS

1.	NUMBER OF MEDICATIONS	*(Record the number of different medications used in the last 7 days; enter "0" if none used)* ☐☐
2.	NEW MEDICATIONS	*(Resident currently receiving medicatons that were initiated during the **last 90 days**)* ☐ 0. No ☐ 1. Yes
3.	INJECTIONS	*(Record the number of **DAYS** injections of any type received during the **last 30 days**; enter "0" if none used.)* ☐☐
4A.	DAYS RECEIVED THE FOLLOWING MEDICATION	**(Record the number of DAYS** during the **last 7 days**; enter "0" if not used. Note--enter "1" for long-acting meds used less than weekly) _____ a. Antipsychotic _____ b. Antianxiety _____ c. Antidepressant _____ d. Hypnotic _____ e. Diuretic _____ f. Aricept _____ g. Insulin
4B.	PRN MEDICATIONS	Does resident have a prescription for any PRN medication for a mental, emotional or nervous condition, or behavioral problem? ☐ 0. No ☐ 1. Yes

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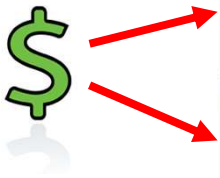
Section O: Medications



5.	SELF-ADMINSTERED MEDICATIONS *(Check all that apply.)*	Did resident **self-administer** any of the following in the last 7 days: ☐ a. Insulin ☐ b. Oxygen ☐ c. Nebulizers ☐ d. Nitropatch ☐ e. Glucosan ☐ f. Over-the-counter Meds ☐ g. Other (specify) _____ ☐ h. *NONE OF ABOVE*
6.	MEDICATION PREPARATION ADMINISTRATION	Did resident prepare and administer his/her own medications in last 7 days? *(Check only one.)* ☐ 0. No Meds ☐ 1. Resident prepared and administrated NONE of his/her own medications. ☐ 2. Resident prepared and administrated SOME of his/her own medications. ☐ 3. Resident prepared and administrated ALL of his/her own medications.

Self-Administration of Medications		If O5f=1, Score = 0; Otherwise Score = 1;	
O5f	Self-administration of over the counter medications		
Medication Preparation and Administration		If O6=0, Score=1; If O6=1, Score=2; If O6=2, Score=1; If O6=3, Score=0;	
O6	Did resident prepare and administer any of his/her own medications		

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MDS-ALS Training

Section Q: Service Planning

SECTION Q. SERVICE PLANNING

1.	RESIDENT GOALS *(Check all areas in which resident has self-identified goals)*	☐ a. Health promotion/wellness/exercise ☐ b. Social involvement/making friends ☐ c. Activities/hobbies/adult learning ☐ d. Rehabilitation–skilled ☐ e. Maintaining physical or cognitive function ☐ f. Participation in the community ☐ g. Other *(specify)* _____ ☐ h. No goals
2.	CONFLICT	a. Any disagreement between resident and family about goals or service plan? ☐ 0. No ☐ 1. Yes b. Any disagreement between resident/family and staff about goals or service plan? ☐ 0. No ☐ 1. Yes

Note: this item refers to **Resident self-identified goals**

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Section R: Discharge Potential

SECTION R. DISCHARGE POTENTIAL

1.	DISCHARGE POTENTIAL	a. Does resident or family indicate a preference to return to community? ☐ 0. No ☐ 1. Yes b. Does resident have a support person who is positive towards discharge? ☐ 0. No ☐ 1. Yes c. Has resident's self-sufficiency changed compared to 6 months or since admission, if less than 6 months? ☐ 0. No change ☐ 1. Improved ☐ 2. Declined

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Section T: Preventive Health

SECTION T. PREVENTIVE HEALTH/HEALTH BEHAVIORS

1.	PREVENTIVE HEALTH	*(Check all the procedures the resident received during the past 12 months)* ☐ a. Blood pressure monitoring ☐ b. Hearing assessment ☐ c. Vision test ☐ d. Dental visit ☐ e. Influenza vaccine ☐ f. Pneumococcal vaccine (ANY time) ☐ g. Breast exam or mammogram ☐ h. Pap smear ☐ i. PSA or rectal exam ☐ j. Other *(specify)* _____

Note: **12-month look back period** for preventive health measures.

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MDS-ALS Training

Section U: Medications list

SECTION U. MEDICATIONS LIST

List all medications given during the last 7 days. Include medications used regularly less than weekly as part of the resident's treatment regimen.

1. List the medication name and the dosage
2. RA (Route of Administration): Use the appropriate code from the following list:

1 = by mouth (PO) 2 = sublingual (SL) 3 = intramuscular (IM) 4 = intravenous (IV) 5 = subcutaneous (SubQ) 6 = rectally 7 = topical 8 = inhalation 9 = enteral tube 10 = other

3. FREQ (Frequency): Use the appropriate frequency code to show the number of times per day that the medication was given.

PR = (PRN) as necessary
1H = (qh) every hour
2H = (q2h) every two hours
3H = (q3h) every three hours
4H = (q4h) every four hours
6H = (q6h) every six hours
8H = (q8h) every eight hours
1D = (qd or hs) once daily
2D = (BID) two times daily (includes every 12 hours)
3D = (TID) three times daily
4D = (QID) four times daily
5D = five times a day
1W = (QWeek) once every week
2W = twice every week
3W = three times every week
QO = every other day
4W = four times every week
5W = five times every week
6W = six times every week
1M = (QMonth) once every month
2M = twice every month
C = continuous
O = other

4. PRN-n (prn — number of doses): If the frequency code is "PR", record the number of times during the past 7 days that each PRN medication was given. Do not use this column for scheduled medications.

5. DRUG CODE: Enter the National Drug Code (NDC). The last two digits of the 11-digit NDC define package size and have been omitted from the codes listed in the manual Appendix E. If using this Appendix, the NDC should be entered left-justified (the first digit of the code should be entered in the space farthest to the left of the NDC code column). This should result in the last two spaces being left blank.

1. Medication Name and Dosage	2. RA	3. Freq	4. PRN-n	5. NDC Codes
EXAMPLE: Coumadin 2.5 mg	1	1W		
Digoxin 0.125 mg	1	1D		
Humulin R 25 Units	5	1D		
Robitussin 15cc	1	PR	2	

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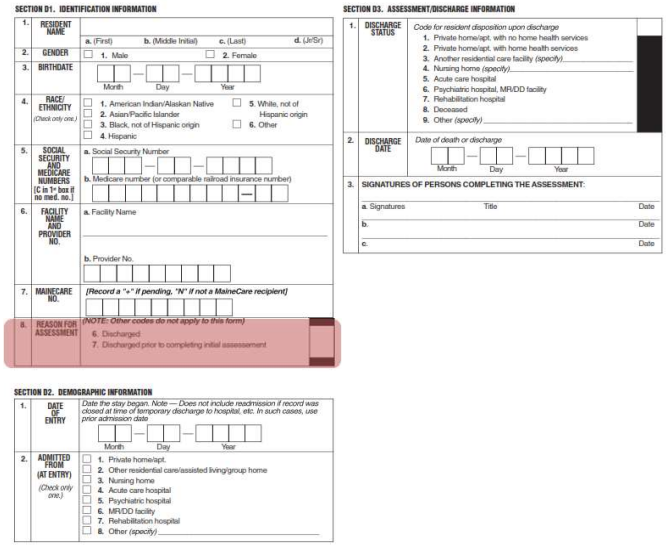
MDS-ALS
Training: Discharge Tracking Form



SECTION D1. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER	1. Male 2. Female
3.	BIRTHDATE	Month Day Year
4.	RACE/ ETHNICITY (Check only one.)	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin 6. Other
5.	SOCIAL SECURITY AND MEDICARE NUMBERS (C in 1st box if no mnd. no.)	a. Social Security Number b. Medicare number (or comparable railroad insurance number)
6.	FACILITY NAME AND PROVIDER NO.	a. Facility Name b. Provider No.
7.	MAINECARE NO.	[Record a "+" if pending, "N" if not a MaineCare recipient]
8.	REASON FOR ASSESSMENT	(NOTE: Other codes do not apply to this form) 6. Discharged 7. Discharged prior to completing initial assessment

SECTION D2. DEMOGRAPHIC INFORMATION

1.	DATE OF ENTRY	Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date. Month Day Year
2.	ADMITTED FROM (AT ENTRY) (Check only one.)	1. Private home/apt. 2. Other residential care/assisted living/group home 3. Nursing home 4. Acute care hospital 5. Psychiatric hospital 6. MR/DD facility 7. Rehabilitation hospital 8. Other (specify)

SECTION D3. ASSESSMENT/DISCHARGE INFORMATION

1.	DISCHARGE STATUS	Code for resident disposition upon discharge 1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Another residential care facility (specify) 4. Nursing home (specify) 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Deceased 9. Other (specify)
2.	DISCHARGE DATE	Date of death or discharge Month Day Year
3.	SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:	a. Signatures Title Date b. Date c. Date

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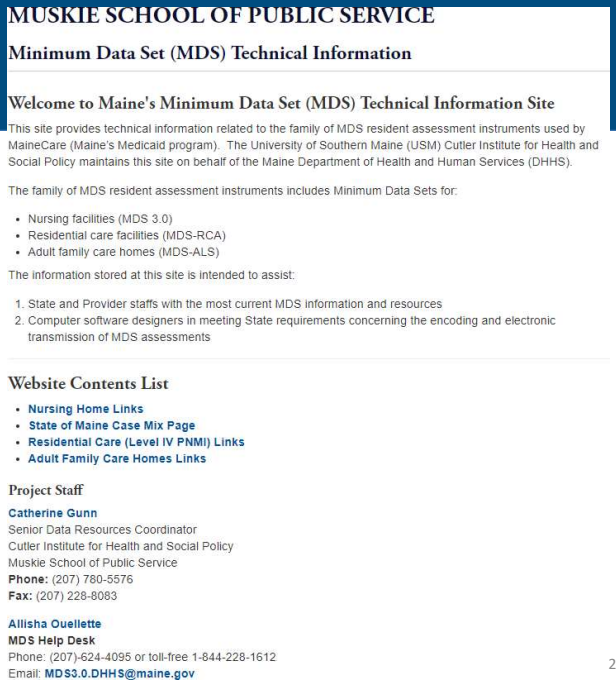
MDS-ALS
Submission

https://usm.maine.edu/muskie/minimum-data-set-mds-technical-information



MUSKIE SCHOOL OF PUBLIC SERVICE

Minimum Data Set (MDS) Technical Information

Welcome to Maine's Minimum Data Set (MDS) Technical Information Site

This site provides technical information related to the family of MDS resident assessment instruments used by MaineCare (Maine's Medicaid program). The University of Southern Maine (USM) Cutler Institute for Health and Social Policy maintains this site on behalf of the Maine Department of Health and Human Services (DHHS).

The family of MDS resident assessment instruments includes Minimum Data Sets for:

- Nursing facilities (MDS 3.0)
- Residential care facilities (MDS-RCA)
- Adult family care homes (MDS-ALS)

The information stored at this site is intended to assist:

1. State and Provider staffs with the most current MDS information and resources
2. Computer software designers in meeting State requirements concerning the encoding and electronic transmission of MDS assessments

Website Contents List

- Nursing Home Links
- State of Maine Case Mix Page
- Residential Care (Level IV PNMI) Links
- Adult Family Care Homes Links

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MDS-ALS Training: Submission

https://sms.muskie.usm.maine.edu/

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MDS-ALS Training: Submission

If you do not submit electronically:

If you do not use software to complete your MDS-ALS, you cannot submit electronically.

You must submit to Catherine via *fax* at: **(207) 228-8083**

DO NOT SUBMIT MDS VIA EMAIL – this is a HIPAA violation and you will be notified

OR

Submit to Catherine via *mail (USPS)*
Please label the envelope specifically to Catherine Gunn and mark CONFIDENTIAL

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MDS-ALS Training: Submission

RCF Report
MDS-RCA Final Validation Report

Facility Name	FACILITY		Provider ID	123456789	Facility ID	00000
Import Date:	# Records Processed	# Records Rejected	# Records Accepted			
3/19/2014	4	1	3			

Rejected Assessments

SSN	Resident Name	Reason For Assessment (A6/D1_8)	Assessment Date	Payment RUG Group	CaseMix / Payment Weight

RCF Report
MDS-RCA Final Validation Report

Facility Name	FACILITY		Provider ID	123456789	Facility ID	00000
Import Date:	# Records Processed	# Records Rejected	# Records Accepted			
3/19/2014	4	1	3			

Accepted Assessments

SSN	Resident Name	Reason For Assessment (A6/D1_8)	Assessment Date	Payment RUG Group	CaseMix / Payment Weight

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MDS-ALS Training

What should you do if you find a pattern of incorrect RUG groups between your MDS and the final validation?

- Call your vendor
- Make sure you are checking your validation reports regularly!

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MDS-ALS Training

What if my *software* shows an assessment has been accepted?

- Check your state validation report from SMS to confirm acceptance or rejection
- Software acceptance means your software is accepting the assessment as ready for submission through SMS.

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MDS-ALS Training

Questions?

This completes session #2 of the MDS-ALS Mini-Series.

Email the help desk to register for training sessions, forum calls or to send questions for the forum call.

MDS3.0.dhhs@maine.gov

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MDS-ALS Training

Reminders:

Quarterly **Res Care Forum Calls** in March, June, September, and December; Call the MDS help desk to register. *We hope to implement an Adult Family Care Home Forum Call soon.*

ASK questions!

ASK more questions!

Attend training as needed

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Case Mix Team Contact Information

- **MDS Help Desk**: 624-4095 or toll-free: 1-844-288-1612
  MDS3.0.DHHS@maine.gov
- **Debra Poland RN**: 215-9675
  Debra.Poland@maine.gov
- **Julia Jason, RN**: 441-8276
  Julia.Jason@maine.gov
- **Emma Boucher RN:** 446-2701
  Emma.Boucher@maine.gov
- **Christina Stadig RN**: 446-3748
  Christina.Stadig@maine.gov
- **Sue Pinette, RN**: 287-3933 or 215-4504 (cell)
  Suzanne.Pinette@maine.gov

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Questions?

Sue Pinette RN, RAC-CT,
Case Mix Manager
207-287-3933

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